2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.321 CORRECTION OF ERRONEOUS OR MISSING DATA

(1) The department will prepare and distribute resident listings to facilities by the 15th day of the third month of each quarter (cut off date). The listings will identify current assessments for residents in the nursing facility on the first day of the second month of each quarter as reflected in the database maintained by the department. The listings will identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source. Resident listings shall be signed and returned to the department by the 15th day of the first month of the following. calendar quarter. Facilities who do not return this corrected resident listing by the due date will use the database information on file in their case mix calculation.

(2) If data reported on the resident listings is in error or if there is missing data, facilities will have until the 15th day of the first month of each calendar quarter to correct data submissions.

(a) Errors or missing data on the resident listings due to untimely submissions to the HCFA database maintained by the department of public health and human services (DPHHS) are corrected by transmitting the appropriate assessments or tracking documents to DPHHS in accordance with HCFA requirements.

(b) Errors in key field items are corrected following the HCFA key field specifications through DPHHS.

(c) Errors on the current payor source should be noted on the resident listings prior to signing and returning to DPHHS.

(3) The department may also use medicaid paid claim data to determine the medicaid residents in each facility when determining the medicaid average case mix index for each facility. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.322 OBRA NURSE AIDE TESTING AND TRAINING COST REPORTING (1) Omnibus Budget Reconciliation Act of 1987 (OBRA) costs will be reimbursed under the per diem rate determined under ARM 37.40.307. No further reimbursement will be provided outside

the per diem rate.

(2) Each provider must document and submit to the department on a quarterly basis information on the nurse aide certification training and competency evaluation (testing) costs, including but not limited to the costs of training for nurse aides and the costs of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing). The required information must be submitted quarterly on the nurse aide certification/training and competency evaluation (testing) survey reporting form provided by the department and must include the total dollars incurred in each of the categories of facility personnel, supplies and equipment, subcontracted services and testing fees. The reporting form must include a brief description of the items included in each of the four categories.

(a) Acceptable documentation will be any documentation that adequately supports the costs claimed on the reporting form and includes all records and documentation as defined in ARM 37.40.346, such as invoices, contracts, canceled checks and time cards. This documentation is subject to desk review and audit in accordance with ARM 37.40.346. This documentation must be maintained by the facility for six years, three months from the date the form is filed with the department or until any dispute or litigation regarding the costs supported by such documentation is finally resolved, whichever is later.

(b) If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346(4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.

(3) Medicaid nursing facility reimbursement for the costs associated with training and competency evaluation programs for nurse aides employed in medicare and medicaid nursing facilities, as required under OBRA, shall be as follows:

(a) Nurse aide certification training and competency evaluation (testing) costs documented in accordance with (2) and allowable under ARM 37.40.345 will be reimbursed to the extent provided under the per diem rate determined under ARM 37.40.307.

No additional reimbursement will be provided for such costs.

(4) For purposes of reporting under (2), nurse aide tests are those tests which:

(a) demonstrate competency through testing methods which address each course requirement and include successful completion of both a written or oral examination and a demonstration of the skills required to perform the tasks required of a nurse aide;

(b) are performed at either a nursing facility which is currently in compliance with medicaid nursing facility participation requirements or at a regional testing site at regularly scheduled testing times;

(c) are administered to nurse aides actually employed by the facility; and

(d) do not exceed a third attempt by the individual nurse aide to successfully complete the portion of the test for which costs are reported. The written/oral examination and the skills demonstration may be taken separately if the nurse aide passed only one portion of the test in a previous exam.

(5) Competency evaluation (testing) costs reported by a provider shall include the testing entity's basic fee charged to the facility and other costs associated with competency testing, to the extent allowable under ARM 37.40.345. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.323 CALCULATED PROPERTY COST COMPONENT (REPEALED) (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.324 GRANDFATHERED PROPERTY COST COMPONENT (REPEALED)

(History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.325 CHANGE IN PROVIDER DEFINED (1) Except as provided in (2), a change in provider will be deemed to have occurred if the events described in any one of the following (1)(a) through (d) occurs:

(a) For sole proprietorship providers, a change in provider occurs where the entire sole proprietorship is sold to an unrelated party and a selling proprietor does not retain a right of control over the business.

(b) For partnership providers, a change in provider occurs where:

(i) a new partner acquires an interest in the partnership greater than 50%;

(ii) the new partner is not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest; and

(iii) the current or former partners from whom the new partner acquires an interest do not retain a right of control over the partnership arising from the transferred interest.

(c) For corporation providers, a change in provider occurs where stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated party.

(d) For all providers, a change in provider occurs where an unrelated party acquires:

(i) the provider's title or interest in the nursing facility or a leasehold interest in the nursing facility; and

(ii) the right to control and manage the business of the nursing facility.

(2) Regardless of the provisions of (1) through (1)(d), a change in provider will not be deemed to have occurred if the circumstances indicate that:

(a) a related party will acquire, retain or actually exercise substantial influence over the new entity; or

(b) the occurrence or transaction is undertaken primarily for the purpose of triggering a change in provider under this rule.

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party" means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity;

(ii) A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3)(b)(i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3)(b)(i); or

(iii) a sole proprietorship, partnership corporation or other entity in which a person described in (3)(b)(i) or (ii) has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal medicare law, regulation or policy or related caselaw regarding changes in ownership under the medicare program are not applicable.

(5) As required in ARM 37.40.306, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the medicaid program in accordance with applicable requirements.

(6) Any change in provider, corporate or other business ownership structure or operation of the facility that results in a change in federal tax identification number will require a provider to seek a new medicaid provider enrollment. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.326 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) This rule specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least six months participation in the medicaid program in a newly constructed facility or following a change in provider as defined in ARM 37.40.325.

(a) Effective July 1, 2001, and thereafter, the rate paid to new providers that acquire or otherwise assume the operations of an existing nursing facility, that was participating in the medicaid program prior to the transaction, will be paid the price-based reimbursement rate in effect for the prior owner/operator of the facility before the transaction as if no change in provider had occurred. These rates will be adjusted at the start of each state fiscal year in accordance with (1)(b).

(b) Effective July 1, 2001, and thereafter, the rate paid to newly constructed facilities or to facilities participating in the medicaid program for the first time will be the statewide average nursing facility rate under the price-based reimbursement system. The direct care component of the rate will not be adjusted for acuity, until such time as there are three or more quarters of medicaid CMI information available at the start of a state fiscal year. Once the CMI information is available the price-based rate will include the acuity adjustment as provided for in ARM 37.40.307(5)(b). (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 27 through 29 reserved

37.40.330 SEPARATELY BILLABLE ITEMS (1) In addition to the amount payable under the provisions of ARM 37.40.307(1) or (5), the department will reimburse nursing facilities located in the state of Montana for the following separately billable items:

(a) colostomy set;

(b) ostomy face plate;
(c) ostomy skin barrier;
(d) ostomy liquid barrier;
(e) ostomy skin bond or cement;
(f) ostomy bag, disposable/closed;
(g) ostomy bag, reusable or drainable;
(h) ostomy belt;
(i) stoma wicks;
(j) tail closures;
(k) ostomy skin bond or cement, remover;
(l) ileostomy set;
(m) ileal bladder set;
(n) irrigation set for irrigation of ostomy;
(o) ostomy lubricant;
(p) ostomy rings;
(q) ostomy supplies not otherwise listed;
(r) ureterostomy set;
(s) ureterostomy supplies not otherwise listed;
(t) colon tube;
(u) disposable colostomy appliances and accessories;
(v) colostomy irrigation appliance;
(w) colostomy irrigation accessory;
(x) colostomy appliance, non-disposable;
(y) colostomy appliance;
(z) disposable ileostomy accessory;
(aa) disposable urostomy bags;
(ab) piston irrigation set;
(ac) blood or urine control strips or tablets;
(ad) dextrostick or glucose test strips;
(ae) implantable vascular access portal/catheter (venous arterial or peritoneal);
(af) indwelling catheter, foley type, two-way, teflon;
(ag) indwelling catheter, foley type, two-way, latex;
(ah) indwelling catheter, foley type, two-way, latex with teflon coating;
(ai) indwelling catheter, foley type, two-way, all silicone;
(aj) indwelling catheter, foley type, two-way, silicone with elastomer coating;
(ak) indwelling catheter, foley type, three-way, latex or teflon for continuous irrigation;

(al) external catheter, condom type;
(am) urinary collection and retention system, drainage bag with tube;
(an) urinary collection and retention system, leg bag with tube;
(ao) catheter care kit;
(ap) catheter insertion tray, without tube and drainage bag;
(aq) three-way irrigation set for catheter;
(ar) uretheral catheter;
(as) catheter miscellaneous supplies;
(at) uretheral catheter with tray;
(au) caudi-tip catheter;
(av) male mentor catheter;
(aw) incontinence clamp;
(ax) urinary drainage bag;
(ay) urinary leg bag;
(az) bedside drainage bag;
(ba) tracheostomy care kit;
(bb) nasopharyngeal/tracheal suction kit;
(bc) oxygen contents, gaseous, per cubic feet;
(bd) oxygen contents, gaseous, per 100 cubic feet;
(be) oxygen contents, liquid, per pound;
(bf) oxygen contents, liquid, per 100 pounds;
(bg) cannula;
(bh) tubing, unspecified length, per foot;
(bi) regulator;
(bj) mouth piece;
(bk) stand/rack;
(bl) face tent;
(bm) IPPB kit;
(bn) portable aspirator;
(bo) connectors;
(bp) face mask;
(bq) nasal catheter;
(br) disposable IPPB tubing;
(bs) disposable humidifier(s);
(bt) extension hoses;
(bu) MADA plastic nebulizer with mask and tube;
(bv) nasal O2 kit;
(bw) O2 contents, linde reservoir;

(bx) O2 contents, liberator;
(by) O2 contents, LV 160;
(bz) O2 contents, PCU reservoir;
(ca) O2 contents, GP-45;
(cb) O2 contents, D cylinder;
(cc) O2 contents, E cylinder;
(cd) O2 cylinder contents, GDL-K;
(ce) cylinder rental, one month;
(cf) piped in oxygen;
(cg) oxygen cart for portable tank (purchase);
(ch) enteral feeding supply kit; syringe (monthly);
(ci) enteral feeding supply kit; pump fed (monthly);
(cj) enteral feeding supply kit; gravity fed (monthly);
(ck) nasal gastric tubing with thin wire or cotton (e.g., travasorb, entriflex, dobb huff, flexiflow, etc.);
(cl) nasogastric tubing without stylet;
(cm) stomach tube - levine type;
(cn) enteral supply kit for prepackaged delivery system (monthly);
(co) nasogastric tubing with or without stylet (e.g., travasorb);
(cp) enteric feeding set;
(cq) flex-flo feeding set;
(cr) nutrition container;
(cs) IV intercath;
(ct) IV tubing;
(cu) IV piggyback tubing;
(cv) parenteral nutrition supply kit for one month - premix;
(cw) parenteral nutrition supply kit for one month - homemix;
(cx) parenteral nutrition administration kit for one month;
(cy) enteral supplies not elsewhere classified;
(cz) parenteral supplies not elsewhere classified;
(da) feeding syringe;
(db) gavage feeding set;
(dc) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for residents who, because of chronic illness or trauma, cannot be sustained through oral feeding. Payment for these solutions will be allowed only where the department

determines they are medically necessary and appropriate, and authorizes payment before the items are provided to the resident;

(dd) routine nursing supplies used in extraordinary amounts and prior authorized by the department;

(de) effective October 1, 1989, oxygen concentrators and portable oxygen units (cart, E tank and regulators), if prior authorized by the department.

(i) The department will prior authorize oxygen concentrators and portable oxygen units (cart, E tank and regulators) only if:

(A) The provider submits to the department documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice.

(B) The provider maintains a certificate of medical necessity indicating the PO2 level or oxygen saturation level. This certificate of medical necessity must meet or exceed medicare criteria and must be signed and dated by the patient's physician. If this certificate is not available on request of the department or during audit, the department may collect the corresponding payment from the provider as an overpayment in accordance with ARM 37.40.347.

(ii) The provider must attach to its billing claim a copy of the prior authorization form.

(iii) The department's maximum monthly payment rate for oxygen concentrators and portable oxygen units (cart, E tank and regulators) will be the invoice cost of the unit divided by its estimated useful life as determined by the department. The provider is responsible for maintenance costs and operation of the equipment and will not be reimbursed for such costs by the department. Such costs are considered to be covered by the provider's per diem rate.

(2) The department will pay as a separately billable item, a per diem nursing services increment for services provided to a ventilator dependent resident if the department determines that extraordinary staffing by the facility is medically necessary based upon the resident's needs.

(a) Payment of a per diem nursing services increment under (2) for services provided to a ventilator dependent resident shall be available only if, prior to the provision of services, the increment has been authorized in writing by the department's